age 50 prompts a completely different solution to the question of whether screening mammography should be done in women 35 to 50 years old. Rather than halting such screening and placing the burden of proof on mammographers to justify the success of their technique with a randomized clinical trial, I propose to continue reaping the benefits of screening and place the burden of proof on radiobiologists to *unequivocally* define and quantitate the risks. Mammography has been done for well over 20 years, and for the first 15 years at radiation doses 25 to 50 times greater than now possible. Yet I am not aware of, and I challenge Breslow to produce, even one proved case of breast cancer resulting from mammography. When dealing with a cancer detection technique even more accurate than the Pap smear, it is inconceivable to abandon that technique on the basis of unproved risk.

Mammography is indeed one of the triumphs of modern radiology. To attempt to discredit it on the basis of insufficient evidence of risk and to also ignore the great majority of evidence demonstrating its utility is overly cautious, misleading and incorrect. I again urge that screening mammography of women age 35 to 50 be continued in the BCDDP.

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## Preventive Medicine and Behavior Change

TO THE EDITOR: Congratulations to Dr. Breitman for his clear, good sense letter in the September 1976 issue [Breitman G: Preventive medicine—A myth. West J Med 125:236, Sep 1976], from one who is actually in the field and not in the dream world.

It occurs to me that perhaps public misunderstanding (intentionally or unintentionally promoted) is due to misuse of the term "preventive medicine." The public may rightfully associate preventive medicine with the great advances in public health due to the work of physicians and medical scientists which controlled the great epidemic and infectious diseases. In that situation the physician was actually able to provide the drug or immunization or sanitation or other factor which resulted in the longevity and freedom from disease we all enjoy. That is real "preventive medicine."

But the "preventive medicine" that the sociologists and politicians are referring to should better be called "behavioral change medicine." The difference is fundamental because the result in this situation isn't ultimately under the control of the physician but depends on the actions of the patient, the public; depends on a change in long-established habits, personalities, environments and a myriad of other factors over which the physician has *no* control.

Our medical-social organizations in dealing with the promotors of this fallacy should insist on a stricter definition. The planners' grand proposal ought be called by something other than the honored term "preventive medicine."

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## Physician's Assistants in California

TO THE EDITOR: In the December issue was a letter [Reade FZ: More on physician's assistants. West J Med 125:498, Dec 1976] by Frank Z. Reade, MD, regarding physician's assistants (PA) misrepresenting themselves as physicians.

I appreciate the concern expressed by Dr. Reade regarding an incident where a physician's assistant identified himself as a physician during a telephone conversation. In no way will an attempt be made to justify the action of any person, PA or not, who intentionally misrepresents himself as a physician.

A physician's assistant is a particularly vulnerable professional—we represent a new and basically unknown concept to the general public. A patient automatically assumes that anyone in a white jacket who does the work of a physician must indeed be a physician, thus he calls this practitioner "doctor" out of respect and tradition. Certainly, to encourage this facade is wrong, but to advocate that every time a PA is called a "doctor" that he immediately retorts with a lengthy dissertation of the role and evolution of midlevel health practitioners is equally unjustified. The classic "What's a PA?" bombards us daily and sometimes we have a tendency not to overempha-